APPEAL NO. 93123

A contested case hearing was held in (city), Texas, on January 13, 1993, (hearing officer) presiding, to determine the correct impairment rating for the respondent (claimant). Concluding that the great weight of the other medical evidence was contrary to the report of the designated doctor which assigned claimant a four percent whole body impairment rating, the hearing officer concluded that claimant's correct impairment rating was 13%, the rating assigned by the appellant's doctor. Appellant (carrier), the workers' compensation insurance carrier for claimant's employer on (date of injury), the date claimant was injured, urges on appeal that the hearing officer erred in failing to give presumptive weight to the designated doctor's report pursuant to the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-4.26(g) (Vernon Supp. 1993) (1989 Act). No response was filed by claimant.

DECISION

Finding we are unable to ascertain how the hearing officer treated the evidence concerning claimant's impairment for a degenerative cervical disc, we reverse and remand.

The parties stipulated that claimant was injured in the course and scope of his employment on (date of injury), and reached maximum medical improvement (MMI) on July 14, 1992. Claimant, employed by (employer) on the date of his injury, was working as an assembler for Integral when a cable spool, which he said weighed between 200 and 300 pounds, fell on his back. He said he saw a "company doctor" twice in August 1991, before commencing treatment on August 16, 1991, with his treating doctor, (Dr. M), who treated him with adjustments and stimulations approximately three times per week and whom he still periodically sees. Claimant testified further that at the request of the carrier he was examined by (Dr. W), who assigned him an impairment rating of 13%, that he disagreed with that rating because it did not include a rating for his shoulder, that (Dr. O), who was subsequently selected by the Texas Workers' Compensation Commission (Commission) as the designated doctor, assigned him an impairment rating of four percent, that he disagreed with Dr. O's rating because it assigned no rating for loss of range of motion (ROM), that he denied invalidating the ROM tests as Dr. O reported, that Dr. M indicated his rating was 37%, and that while he understood others disagreed with the high rating of Dr. M, he felt it "unfair" to be given only the four percent rating of the designated doctor.

The carrier called employer's personnel manager who testified that claimant failed to disclose any prior work-related injuries or claims on his employment application. Carrier also introduced occupational injury documents reflecting workers' compensation claims for back and/or neck injuries on June 23, 1989, and December 13, 1990. Claimant acknowledged the two prior workers' compensation claims conceding he failed to disclose them to employer. The carrier urged that this evidence was relevant to the issue of claimant's credibility, not only with employer but with the designated doctor's testing.

Records from (Medical Center), dated August 2 and 5, 1991, were introduced by the

carrier. The August 2nd record reflected that claimant's chief complaint was a back injury with progressive back pain from between his shoulder blades to his pelvis, that he denied head or neck injury, weakness, numbness or tingling to legs, or prior back problems, and that he had treated himself with a heating pad. The impression of the Medical Center doctor, (Dr. N), was "contusion to back." He ordered x-rays, prescribed medications and bed rest, and scheduled a follow-up visit on August 5th. On Claimant's August 5th visit he complained of feeling worse and of intermittent tingling on his hands and left leg. Dr. N's diagnosis was contusion and strain to the thoracolumbar spine, and his treatment plan of bedrest, warm moist towels, and medications was continued.

The next medical record in evidence was the Report of Medical Evaluation (TWCC-69) of (Dr. W), accompanied by his narrative report dated July 14, 1992. According to Dr. W's narrative report, at the time of his examination claimant had been working for three months operating a forklift and sweeping and cleaning, but still had complaints about his back, neck, and left shoulder. Dr. W noted that x-rays of the cervical and thoracolumbar spine, and of the hips and left shoulder, showed no evidence of fracture or dislocation, that myelograms of claimant's cervical and lumbar spines were normal, that an MRI of his cervical spine was normal, and that an MRI of his lumbosacral spine showed an L4-5 bulge. Dr. W also noted that claimant, a 30-year-old male weighing 245 pounds, "gets on and off the examining table with ease," and was neurologically intact. Dr. W's impression was cervical strain, thoracic strain, lumbar radicular syndrome with left leg and hip pain, and left shoulder pain. Dr. W stated that the ROM of claimant's cervical spine and lumbosacral spine was "recorded," that claimant showed normal ROM in his left shoulder and thoracic spine, and that claimant was "rather apprehensive during the entire exam and complains of pain to palpation over the entire spine." There was no indication in Dr. W's report of his being unable to assess ROM loss or of the invalidity of ROM testing. Dr. W certified that claimant reached MMI on July 14, 1992, and assigned him a whole body impairment rating of 13% consisting of five percent for a degenerative disk at L4-5, four percent for loss of cervical spine ROM, four percent for loss of lumbar spine ROM, and zero percent for his thoracic spine and left shoulder.

Dr. W's report goes on to state that claimant was seen by (Dr. D) and "given a 29% disability rating" which the carrier questioned and which resulted in the carrier's requesting Dr. W to provide another opinion. Dr. W states that "[Dr. D] gave him a disability rating on the basis of disc disruption and range of motion loss, pain, etc." No records or reports from Dr. D were in evidence and the record was not clear as to whether Dr. W reviewed records from Dr. D or was simply provided that information by the claimant.

The TWCC-69 from the designated doctor, Dr. O, assigned claimant a four percent impairment rating. Dr. O's accompanying narrative report, dated September 25, 1992, stated that a September 21, 1992 MRI revealed minimal degenerative changes at C5-6 which would equate to a four percent impairment and that the MRI of claimant's lumbar spine was unremarkable. Dr. O noted that on physical examination claimant demonstrated

full strength of his biceps and deltoids against resistance, as well as his wrists and fingers, and that claimant's hip, leg, and toe muscles were within normal strength limits. Respecting loss of ROM, Dr. O commented as follows:

". . . upon physical examination, there was no loss of range of motion in the neck. The lumbar evaluation was considered invalid. There was an improper ratio between the sacral and lumbar flexion angles. He invalidated the repeat evaluation, as well. His tightest straight-leg exceeded the sum of the sacral flexion extension by more than the 10 degrees allowable. Again, he had an improper ratio between the sacral and true lumbar flexion. Therefore, [ROM] studies were considered invalid.

Dr. O also reported that when looking at claimant's loss of sensation, "this patient's responses were non-anatomical in the upper extremity and considered invalid in the lower extremity for sensory abnormalities." Dr. O's report went on to state the following:

We then administered the University of Michigan's Static Strength Testing Model. However, this patient had four of ten minimal efforts, three of seven co-efficients of variation off, and, quite frankly, findings that were impossible. For instance, he had a two-hand pull-in of only 8 lbs., yet, he was noted to easily walk in and out of the testing room facility using only one hand. This door requires a minimum 12 lb. pull.

In addition, he had seven of ten co-efficients of variation, with many above the 20% variation. The Third Edition Revised Guides state quite clearly that if variances over 20% are seen, then the patient is not giving maximum efforts and should be considered invalid. Literature is rather extensive, particularly by Dr. Leonard Matheson at the Rehab Institute of California. He has coined the term "symptom magnification" for these patients.

We also had the patient perform the Progressive Lifting Techniques as developed by the Rehab Institute of California. However, he would only lift 11 lbs., yet, his heart rate only rose from 57 to 67 bpm.

Other questionable validity studies were six positive Waddell signs, a positive Trochanteric Pressure Test, as well as the above mentioned results. Therefore, the only valid impairment for this patient was the minimal changes in the neck as revealed in the x-rays.

Claimant offered no medical records from Dr. M but did introduce Dr M's report dated October 5, 1992, which reviewed and disagreed in part with the report of Dr. O. Dr. M's

report indicated that lifting tests given claimant on October 1, 1992 were within normal limits for variability except for the leg lift, and that the co-efficient of variability in his strength testing, compared with earlier testing in June 1992, indicated "a consistent, maximal effort governed by pain." Dr. M's report also stated that ROM testing was done on October 5, 1992, without difficulty or inappropriate testing, and he found ROM deficits in the cervical, thoracic, and lumbar spines, as well as the right and left shoulders, for which he assigned impairment ratings. Dr. M found additional impairments based on ulnar neuropathies, a mild left thoracic outlet syndrome, a right pronator entrapment syndrome, and a median nerve entrapment. Dr. M's report agreed with Dr. O's report that claimant had four percent impairment rating based on his degenerative cervical disc, but went on to find a total whole body impairment rating of 37% which he summarized as follows:

> The 17% whole person impairment from the decreased lumbar [ROM] is combined with the 10% whole person impairment from the right upper extremity to yield 25% whole person impairment. This is combined with the 6% whole person impairment for the cervical [ROM] to yield a 30% whole person. This is combined with the 5% impairment of the left upper extremity to yield 34%.
>
> This is combined with the 4% for the cervical degeneration at C5/C6 to yield 37% total impairment whole person.

Dr. M also said he concurs "with Dr. O's decision not to give the L4/L5 disc an impairment at this time."

Article 8308-4.26(g) provides that "the report of the designated doctor selected by the commission shall have presumptive weight and the commission shall base the impairment rating on such report unless the great weight of the other medical evidence is to the contrary in which case the commission shall adopt the impairment rating of one of the other doctors."

The hearing officer found that Dr. M's 37% impairment rating included "impairment values for decreased [ROM]," that Dr. W's 13% impairment rating included "impairment values for decreased [ROM]," that Dr. O based his four percent impairment rating solely on "minimum degenerative changes at C5-6" and "invalidated all [ROM] impairment values of the Claimant based upon symptom magnification," and that claimant's impairment rating was 13%. No specific finding was made regarding the 29% rating assigned by Dr. D based, in part, upon loss of ROM. The hearing officer then concluded that "the great weight of all the medical evidence is to the contrary" of Dr. O's four percent whole body impairment rating and indicates claimant's correct impairment rating is 13%.

We have previously stated that a hearing officer who rejects a designated doctor's report because the great weight of the other medical evidence is to the contrary must clearly detail the evidence relevant to his or her consideration, clearly state why the great weight of

the other medical evidence is to the contrary, and further state how the contrary evidence outweighs the designated doctor's report. *See* Texas Workers' Compensation Commission Appeal No. 92570, decided December 14, 1992, Texas Workers' Compensation Commission Appeal No. 92690, decided February 8, 1993, Texas Workers' Compensation Commission Appeal No. 93007, decided February 18, 1993, Texas Workers' Compensation Commission Appeal No. 93021, decided February 19, 1993, Texas Workers' Compensation Commission Appeal No. 93039, decided March 1, 1993, and Texas Workers' Compensation Commission Appeal No. 93072, decided March 12, 1993. The hearing officer's discussion and analysis of how "the great weight of all the medical evidence" was contrary to Dr. O's report is minimal at best. In his discussion the hearing officer refers to the mention "in medical reports" of a "disability rating" of 29% having been given claimant in January 1992 by Dr. D., comments that, "[s]ignificantly, [Dr. W] was able to conduct acceptable range of motion tests of the claimant," and that "[w]orthy of note here is the fact that [Dr. O] assigned no impairment rating for loss of motion. His report indicates that for a number of reasons (collectively referred to as `symptom magnification') the Claimant invalidated all of the [ROM] tests."

From his sparse comments in his discussion of the evidence, it appears the hearing officer viewed the great weight of the other medical evidence as establishing that claimant did have some impairment based on loss of ROM in addition to impairment for a degenerative disc. Respecting claimant's cervical spine, Dr. O found there was no loss of ROM, and he was unable to determine whether claimant had loss of ROM in his lumbosacral spine due to the invalidity of the testing. On the other hand, Drs. W and M both conducted ROM testing of claimant's cervical and lumbosacral spines, found loss of ROM, and assigned impairment ratings therefor. Further, the uncontradicted evidence, albeit through oblique reference in Dr. W's report, is that Dr. D also assigned impairment for loss of ROM, though we do not know which spinal areas were affected.

Dr. W attached to his report, on forms from the Guides to the Evaluation of Permanent Impairment published by the American Medical Association (AMA Guides) (*see* Article 8308- 4.24), his recordings of his ROM findings for claimant's cervical and lumbar spines which showed that each test was repeated three times. In Texas Workers' Compensation Commission Appeal No. 92335, decided August 28, 1992, we discussed the assignment of impairment ratings and ROM assessments in the context of the AMA guides, noted that the AMA Guides address both the protocols for measurements and the evaluative processes, and stated:

Specifically with regard to ROM of the spine, the Guides set forth the recommended tests and procedures and provide for calculating variability between these tests to see whether the measurements fall within reproducibility guidelines; if they do not, the test is determined to be invalid . . . Thus the AMA Guides contain safeguards to validate the tests and make them more reliable.

While he apparently rejected the designated doctor's report because he viewed the great weight of the other medical evidence as being to the contrary respecting impairment ratings for loss of cervical and lumbar ROM, the hearing officer appears to have overlooked the fact that Dr. W's report, which he adopted, assigned a five percent impairment rating for a degenerative disc at L5-6, whereas Dr. O (with whom Dr. M agreed) assigned a four percent rating for a degenerative disc at C5-6. Dr. O found claimant's lumbar spine to be essentially unremarkable, based on an MRI performed on September 21, 1992, and Dr. M stated that the L5-6 disc had "obviously improved" but felt the "normal finding" on the more recent MRI did not rule out "internal disc disruption" at that level. Thus, while the great weight of the other medical evidence may have supported the impairment rating for claimant's loss of ROM in the cervical spine or the lumbar spine or both, if would not appear to support an impairment rating for the L5-6 disc for which Dr. W assigned a five percent rating. The hearing officer made no specific findings regarding an impairment rating for the C5-6 disc vis-a-vis the L4-5 disc, nor did he mention such in his discussion. We are unable to ascertain whether the hearing officer, in adopting Dr. W's report in lieu of Dr. O's report pursuant to Article 8308-4.26(g), concluded that claimant should have a five percent impairment rating for his L4-5 disc problem and zero percent for his C5-6 disc problem. Accordingly, we must reverse and remand.

The decision of the hearing officer is reversed and the case is remanded for the expedited development of additional evidence, as appropriate, and for such additional findings and consideration as are appropriate and not inconsistent with this opinion.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Texas Workers' Compensation Commission's division of hearings, pursuant to Article 8308-5.41. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

Philip F. O'Neill
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Susan M. Kelley
Appeals Judge